

APPLICATION FOR CERTIFICATE OF NEED

Outpatient Surgical Facility/Ambulatory Surgery Center

READ THE ENTIRE APPLICATION FORM PRIOR TO COMPLETING THE QUESTIONS

1. Applicant Name _____

2. Name of Facility _____

3. Address _____
Street City County Zip

4. Person responsible for this project _____

Telephone _____ FAX _____

E-mail: _____

5. Type of ownership: Proprietary ___ Nonproprietary ___

6. Will the sponsor/owner be the operator? Yes ___ No ___

If no, provide the name of the operator or management firm: _____

7. Will the facility be leased? Yes ___ No ___

If yes, to/from whom _____

Monthly Cost _____

Term _____

Total cost of a one year lease _____

Attach a schedule of leases associated with the proposed project. Indicate the term of lease, monthly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.

8. Will any of the equipment be leased? Yes ___ No ___

If yes, what equipment (list) _____

Monthly Cost _____

Term _____

Total value of the lease, including sales tax, delivery and installation _____

Attach a schedule of leases associated with each piece of equipment. Indicate the term of lease, monthly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.

9. Attach a list of the names and addresses of all persons holding ten (10) percent or more equity in the facility.
10. If the facility is incorporated, attach a list giving the name, address and position of each corporate officer.
11. Name of Administrator, Director or CEO: _____

DESCRIPTION OF PROJECT

12. Provide a detailed narrative description of the proposed project (e.g., Does this involve constructing, remodeling, purchasing or leasing of a building? What equipment will be needed? How many operating and recovery rooms will there be? Etc.)

12a. Provide information about the procedures that will be offered.

13. Fill out Exhibit 1 to indicate the total square footage of space planned and divide this into clinical patient treatment exam and surgical areas, office, administration, and indirect service areas such as corridors and mechanical space. Also:

13a. Explain your rationale for the space allocated and why you believe it is adequate.

13b. Provide schematic drawings for the proposed project.

14. Describe in detail your contact with regulatory entities such as the state fire marshal, Department of Inspections and Appeals, and city zoning commission for approval of your project. With whom at these entities did you correspond? Provide copies of any correspondence with these entities.
15. Describe how you will adhere to current Life Safety Codes.
16. Will you seek accreditation (i.e., from AAAASF or other accreditation body) for your facility? What are the associated costs?
17. Will you seek Medicare certification as an ASC? Yes _____ No _____
18. For applicable items, indicate anticipated date for:

Completion of Construction/Modernization _____

Offering of Services _____

NEED DETERMINATION

- 19. In detail, describe the need for the proposed project.
- 20. On an attachment, provide for the proposed service and for relevant ancillary services:
 - 20a. Historical utilization statistics for each of the most recent three years, if applicable.
 - 20b. Expected utilization statistics for each of the first three (3) years after the proposal is operational (list assumptions used).
- 21. What do you consider to be the geographic service area for this project?
- 22. Where are the area residents now receiving services similar to those proposed? Provide the names and addresses of providers offering similar or the same services, including hospitals, located in the geographic area noted in Q. #21. What volume of service are others providing?
- 23. What will be the impact of your proposal on the service volume of other providers? Please explain your assumptions.
- 24. State any other indicators of community need for this proposal.
- 25. As part of the public notice requirement, send a letter to each outpatient surgical service provider (including hospital-based) and ambulatory surgery center in the county stating that you are applying for a certificate of need and briefly describing your project. Attach a copy of the letter to this application.

PERSONNEL

- 26. Attach a list of the medical staff, by specialty, who will supervise the operation of the project. If certain physicians have particularly relevant experience or interests, please elaborate. Which of these physicians will normally be on the premises during operating hours?
- 27. What arrangements between your program and other health care providers have been made or are being proposed to refer emergencies, share services, and provide backup? Attach a copy of any formal agreements.
- 28. Specify your existing and forecasted full-time equivalents (FTEs):

<u>Department</u>	<u>Current</u>	<u>Forecasted</u>
Administrative	_____	_____
Physician(s)	_____	_____

Nursing:	RN	_____	_____
	LPN	_____	_____
	Aides/Orderlies	_____	_____
	Therapists (specify type)	_____	_____
	Other (specify)	_____	_____
	TOTAL FTE'S	_____	_____

29. If new/additional personnel will be needed as a result of the proposed project, attach a statement describing what evidence there is that these personnel will be available and the plans your facility has for recruiting and employing them.
30. Describe plans for providing training and experience to new and existing personnel. Address legal limitations of professional practice.

FINANCIAL FEASIBILITY

31. What do you propose to charge for each service provided? What are the charges for similar services from other providers in your area? Please elaborate regarding comparability of service and any cost savings involved (i.e., if the physician fee is included in your charge it should be included in area wide charge comparisons).
32. Attach a budget for each of the first three years of operation. Project revenue and expenses, and comment on variable line items that could be cut if revenue does not meet expectations.
33. By source, indicate the percentage breakdown of total patient revenues for your facility.

Private Pay	_____
Medicare	_____
Medicaid	_____
BC/BS	_____
Other private insurance	_____
Other (specify)	_____
TOTAL	=====

34. Provide a description of the liability insurance you propose to carry, along with any other information which substantiates that your project will either be financially viable or will have adequate subsidy to assure reasonable patient charges.
35. Fill out Exhibit 2 to itemize capital costs and anticipated depreciation. If your project does not expect to include depreciation and interest expense reimbursement through Medicare, Medicaid or other insurer, please explain briefly how this cost will be recovered (e.g., through patient charges, owner's income taxes, etc.)
36. What will be the source of capital funds? Attach a description of asterisked items.

	<u>Estimated Amount</u>
Cash on Hand	_____
Borrowing*	_____
Federal Funds*	_____
State Funds*	_____
Gifts/Contributions*	_____
Lease**	_____
Other (specify)	_____
TOTAL	_____

*For borrowed funds, please attach a letter from the bond consultant or the lender, indicating the probable terms. Also attach an amortization schedule for the life of the loan, showing the total debt service per year and the portion of each payment that is principal and which part is interest.

**Attach a copy of the proposed lease.

37. Attach audited financial statements and notes for each of the three most recent years. Attach a balance sheet forecasting after three years of operation.

OTHER CRITERIA

38. Explain how the proposed project will contribute to meeting the needs of the medically underserved, including persons in rural areas, low-income persons, racial and ethnic minorities, persons with disabilities, and the elderly.

39. Describe what potentially less costly or more appropriate alternatives to the proposed project including but not limited to staffing, scheduling, design service sharing, etc., were considered and rejected. Specify the reasons therefor.
40. Describe what impact the proposed project will have on-the distance, convenience, cost of transportation, and accessibility to health services for persons who live outside metropolitan areas.
41. Explain how existing facilities providing services similar to those proposed are being used in an efficient and appropriate manner.
42. Describe how patients will experience serious problems obtaining care of the type proposed in the absence of that proposed service.

CERTIFICATION

I, the undersigned, certify that:

I have read Chapter 135.61-.83 Code of Iowa and the Administrative Rules (641 IAC 202 and 203) promulgated pursuant thereto; and

I have read this application, including all exhibits and attachments, and the information therein is, to the best of my knowledge and belief, accurate and true.

Signature of Owner or
Chairperson, Board of Directors

Printed Name

Position or Title

Date

If you wish to designate an official representative to act on your behalf, as addressee for written notifications and/or to speak for you before the Health Facilities Council, specify below:

Name _____

Organization _____

Address _____

Telephone _____

Email _____

Exhibit 2
Estimate Application of Funds and Estimate Depreciation

<u>Application of Funds</u>	<u>Estimated Amount</u>	<u>Estimated Average Useful Life</u>	<u>Estimated First Year Depreciation</u>
1. Site Costs:			
Site Acquisition	\$ _____		
Demolition of Existing Structures	\$ _____		
Site Preparation	\$ _____		
Other (Specify)	\$ _____		
Subtotal	\$ _____		
2. Land Improvements (Specify)			
	\$ _____		
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3. Construction Costs (all areas must meet current applicable Life Safety Codes):			
General (Construction Shell)	\$ _____	_____	_____
Heating, Ventilating, A/C	\$ _____	_____	_____
Plumbing	\$ _____	_____	_____
Electrical	\$ _____	_____	_____
Elevator	\$ _____	_____	_____
Other Fixed Equipment	\$ _____	_____	_____
Architectural	\$ _____	_____	_____
Construction Management, Supervision, Engineering, Testing, Inspection	\$ _____	_____	_____
Other (Specify)	\$ _____	_____	_____
Subtotal	\$ _____	_____	_____
4. Movable Equipment (list each item and its cost)			
	\$ _____	_____	_____
5. Equipment Lease (list each item and its cost)			
Total value including sales tax, delivery and installation			
Annual Cost	\$ _____		
6. Land Lease			
Annual Cost	\$ _____		
7. Facility Lease			
Total cost of a one year lease			
Annual Cost	\$ _____		
8. Financing Costs:			
Underwriters' Discount	\$ _____		

Pricing Discount	\$ _____
Feasibility, Legal, Printing & Other	\$ _____
Interest Expense	
During Construction	\$ _____
Less Interest Earned	
During Construction	\$ _____
Other (Specify)	\$ _____
Subtotal	\$ _____

TOTAL PROJECT COSTS \$ _____

Other Applications:

Debt Service Reserve Account	\$ _____
Other (Specify)	\$ _____
Subtotal	\$ _____

Total Application of Funds \$ _____